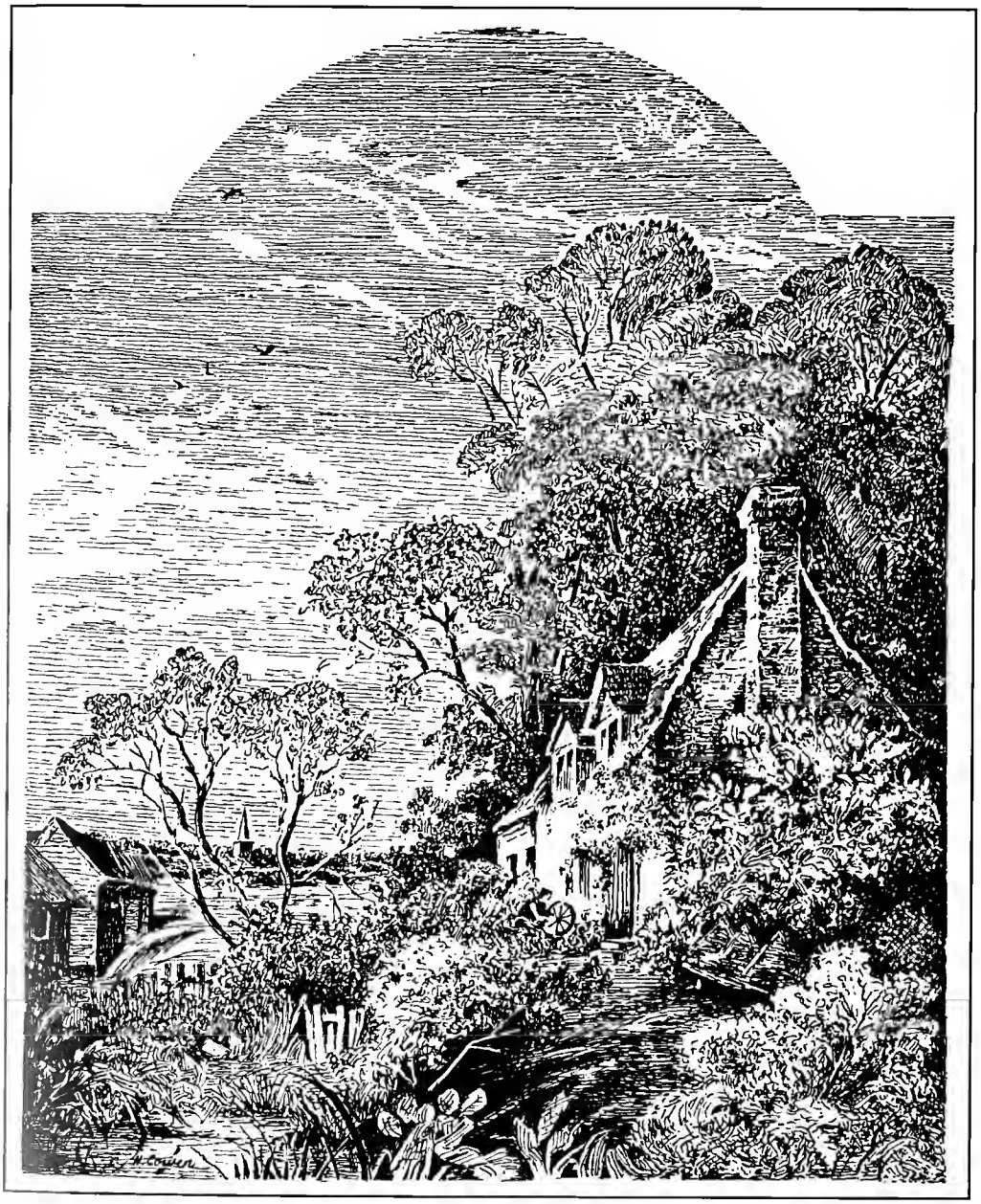
BULLETIN

Founded 1872

Vol. 63, No. 5 Bulletin of The Mahoning County Medical Society September/October 1993



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The *Bulletin* is published six times a year by the Mahoning County Medical Society, 5104 Market Street, Youngstown, Ohio 44512.
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Medical Society Involvement in the Community

Before my tenure draws to a close, I want to encourage our Society's closer interaction with two previously neglected areas of the community, where I believe common areas of interest exist. The first of these involves joint meetings and projects with the Bar Association, and the second, dialogue and forums with representatives of local management and labor.

We had our first meeting with representatives from the Bar on September 28. The purpose was to establish areas of common ground and goodwill where very little dialogue had existed before. For example, it was pointed out that although some physicians may have experience in giving testimony, most of us have very little knowledge of what is involved. The attorneys offered to help educate physicians on issues, such as giving testimony or responding to subpoenas, to improve the practical working relationship of the two professions. This could be done either in the form of seminars or forums, or as articles in the *Bulletin*. Likewise, the attorneys asked if physicians would be willing to give some basic lectures on anatomy, physiology, or other medical topics. We could also jointly sponsor local seminars on difficult ethical issues such as termination of life support, selection of patients for tissue transplants, etc.

One particular area of common interest is the various models of alternative dispute resolution. We discussed the formation of arbitration/review panels (with two physicians and two attorneys each, for example). These panels could give a neutral evaluation on the merit of a case. Some localities have used so-called summary trials, where attorneys for each side plead their case to a six member jury. The verdicts can be split, are non-binding and non-admissible, but might avoid more costly and time-consuming litigation. Attorney Jim Evans, who headed the discussion, offered to do some research to find out what other localities in Ohio are doing in this area, and what results they are seeing.

The suggestion was made that both the Medical Society and the Bar Association poll their membership for issues which they would like discussed. For example, both groups could look for sources of frustration and try to address those areas constructively, perhaps through a medical/legal symposium. Likewise, there are legislative recommendations that could be developed jointly between the Bar and the Medical Society, to be presented to our local congressmen.

Another area where we have barely scratched the surface is to establish a similar dialogue with local labor and industry leaders. There are such monumental changes going on in health care, both at the national and statewide levels, that I think we have developed a certain fatalism and even paralysis when it comes to tackling issues at a local level. Although the Society has taken an active role in educating the public, such as with the Health Matters Live Line TV program and the booth at the Canfield Fair, and has taken the lead in establishing good liaison with some of our legislators, we have not sought out discourse with other key segments of our community.

At a recent panel for the Lake to River Coalition, which included physicians and hospital administrators as well as labor and industry leaders, the need for further dialogue was expressed by many of those in attendance. The primary areas of concern appeared to be the unusually high costs of medical care in this region, and for certain procedures and institutions in particular, high utilization rates for certain procedures and services, and how the rapid increase in these costs threatens to shift ever more jobs elsewhere. Several lay participants expressed their appreciation for the open dialogue by the panel on these issues and hoped for more input as to what the community as a whole, and physician influence in particular, could do to reduce these utilization patterns and costs.

Physicians have long been frustrated in their efforts to be represented in regulations of pricing and utilization issues by the lack of antitrust reform. This was pointed out sev-

Eric W. Svenson, MD
President

eral times during the panel discussion. Open and frank discussions among physicians and other community groups such as this can help educate all segments of the community as to the most pressing issues surrounding health reform and can lead to a better understanding of the opportunities and limitations involved in solving those issues. □

The following applications for membership were approved by Council:

First Year

William T. Bartels M.D.
Maurica A. Batlle M.D.
Sergul A. Erzurum M.D.
Michael L. Scavina M.D.

Active

Jeffrey R. Rubin M.D.

Information pertinent to the applicants should be sent to the MCMS by November 19, 1993.

Mahoning County Medical Assistants

Annual Educational Seminar

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Reading the Mail

I hate reading the mail at my office. I don't even like reading the mail at home. By the time I get to the mail at the office, my staff has already removed the checks so nothing else can really be interesting or "good." Oh sure, there may be yet another fascinating, unsurpassable practice opportunity beckoning in rural Kentucky, or I can find out just how rewarding it can be to work in the federal prison system just by returning the postage paid card (talk about a captive audience). Another of my personal favorites is the computer-generated "Dear Dr. Nash: Thank you for taking the time to talk to me about ..." For crying out loud, I only signed his stupid form; I didn't even tell him to go fish. Certainly it's nice to see that lump you felt was only fibrocystic tissue (then the disclaimer at the bottom says there is a 7 percent to 15 percent false negative rate with mammography anyway). And it's nice to see all those labs we draw every month on all those nursing home patients are still coming back within normal limits (well, close enough). Of course, I already knew that because the nursing home has already faxed me the results ... twice. A little lump in my throat when I see "Law Offices of ..." Phew ... he specializes in workers compensation. See what I mean, nothing really good or just tedious forms and tripe.

Wait a moment ... here's something interesting ... from the Democratic National Committee. From The President himself (even signed it "Bill"). Hmmm ... basically soliciting a contribution (sorry, not tax-deductible) to build the Clintons' war chest for the upcoming health system reform battle. Don't get me wrong, I voted for the guy. (I can see Jim Anderson just shaking his head.) And don't worry, I'm not going to elaborate why I think this is a necessary evil. After all, this is an evil that has momentum at this point. The problem is I just paid my dues for the OSMA and the Mahoning County Medical Society. I even paid my AMA dues this year. Not that I think they will be especially careful to spend my hard-earned $400 wisely, the point is who else is going to protect my interests in the rush to overhaul the health system?

In the two years that I have been active in the Society, I have been impressed by the number of physicians who carry some long-standing grudge about some perceived slight or some imagined (or real) injury that the Society or the OSMA or the AMA did to them. And so they took their marbles and went home to pout. Now I'll start to sound like Norton German–in Council, it really sends Norton off when the subject of members not paying their dues comes up. He (rightly) points out these members continue to receive the benefits of membership (you know, the sumptuous meals at the Youngstown Club, the prestige of membership, timely information about developments on the political front) yet don't pay their freight. But worse than late paying members are the physicians who have some wild hair up their back side because of some bruised ego or some ideological difference with the organization of medicine. I suppose when the finalized format of health system reform comes down the pike, they'll think of some way to blame the AMA or something.

You see, at this point, the decision to join the MCMS and the OSMA and the AMA is just like voting ... you can't complain about the results if you don't vote. At this juncture, I don't see any other meaningful way for physicians to impact the course of health system reform unless they join together. Certainly, physicians as a group are very diverse and often fragmented by the agendas of our various specialty organizations. But when it comes down to bargaining power at the table I would prefer a physician spoke for me and my patients' interests than a politician or insurance company. And for Pete's sake, if you don't agree with a particular position of the Society or the OSMA or the AMA, speak up! Be heard ... we'll listen! The only way the organization can change is from the inside. If you're not involved, we all lose.

I thank you if you have already paid your dues (for what it's worth ... you did yourself a favor). If you haven't, I would ask you to sign that check NOW because, believe me, the battle lines are being drawn. If you know a "wild hair" colleague, or somebody who has never thought membership was important or worthwhile, talk to them. Ask them to join the Society so their weight can be added to our voice at the table. After all, membership dues may be tax deductible! □

L. Kevin Nash, MD

AMA Political Education Conference

During the week of September 28 - 30 the A.M.A. held its bi-annual conference on political education in Washington, D.C. As a member of the OMPAC board I was able to attend. The timing of the meeting was truly serendipitous having just followed President Clinton's address to the nation regarding health care reform.

Senate and congressional leaders spoke to the conference attendees regarding the status of health care reform proposals on the hill. The administration was represented by Donna Shalala, secretary of Health and Human Services, who gave the key note speech. Key democrats who support the president's program spoke also and included Senators George Mitchell, Jay Rockefeller and Representative Richard Gephart.

Former Ohio Governor Richard Celeste, serves as the front man for the administration program. He stated that the health care reform issue is "a campaign with an elastic time table."

The Republicans' position was presented by Senator Robert Dole and Representatives Robert Michel and Newt Gingrich. Newt Gingrich stressed bipartisanship on areas of agreement quickly. Then, debate on the issues of disagreement could take place and this way the "American people would not be held captive." They are co-sponsors of HR 3080 "The Affordable Health Care Now Act of 1993" which has 115 supporters. This plan promotes personal responsibility through medical savings accounts.

The congressional leaders were in agreement that the issues of tort reform and antitrust relief for physicians

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Summer Fellowship Program

A Youngstown elementary school teacher and five minority high school students from Akron, Youngstown, and Cleveland conducted research this summer at the Northeastern Ohio Universities College of Medicine (NEOUCOM).

Ms. Janet Pugh-Freeman of Youngstown participated in the Summer Fellowship Program for Science Teachers. The fellowship program, funded by the National Institutes of Health's (NIH) Center for Research Resources, provides an opportunity for minority teachers, or teachers with a significant number of minority students, to update their knowledge and skills in modern research tools and techniques.

The research activity provided Pugh-Freeman with hands-on experience to strengthen her teaching skills and with the opportunity to take back to the classroom a sense of the excitement of research. The intent is to stimulate her pupils to pursue careers in science.

Ms. Pugh-Freeman worked under the guidance of Timothy Teyler, Ph.D., professor of neurobiology. She and Teyler developed a series of animated cellular physiology teaching modules. Together they designed modules using computer graphics for use by elementary, junior, and high school students. The animations present concepts in biology in a new and engaging fashion.

Ms. Pugh-Freeman, a fifth grade teacher at Sheridan Elementary School in Youngstown, has a bachelor's degree in education from the Ohio State University and is in the master's program at Kent State University.

Five area high school seniors participated in a summer research apprentice program at NEOUCOM this summer. They were Jhera Bundy of Youngstown (East High School), Pierre Vines of Maple Heights (Maple Heights Senior High School), Jennifer Williford of Cleveland Heights (Cleveland Heights High School). Nana-Hawa Yayah of Youngstown (Ursuline High School) and Roselee Zunguze of Akron (Central-Hower High School).

The apprenticeship promotes an interest among minority students in pursuing careers in biomedical research and the health professions. The eight week program targeted minority students who completed their junior year in high school and are enrolled in college preparatory classes emphasizing the sciences and mathematics.

Each student worked under the supervision of faculty conducting scientific research in health-related areas. The NEOUCOM faculty helped the students develop an understanding of research and the technical skill involved in completing research projects. The students were also involved in exercises designed to strengthen their awareness of the basic medical sciences. The students also had the opportunity to meet and work with NEOUCOM's medical students.

NEOUCOM faculty mentors in this year's program were Stephen DiCarlo, Ph.D., assistant professor of physiology; John Docherty, Ph.D., professor and chairman of microbiology/immunology; Kenneth Rosenthal, Ph.D., professor of microbiology/immunology; and Philip Westerman, Ph.D., professor of biochemistry/molecular pathology.

• • •

Also this summer at NEOUCOM, 47 students from approximately 30 high schools throughout northeast Ohio participated in MEDCAMP. MEDCAMP, in its third year at NEOUCOM, provides entering high school students with a hands-on science learning experience. Preference is given to minority, female, and rural students who have demonstrated achievement in science and medicine. Students participate in laboratory sessions in microbiology, anatomy, physiology, physical diagnosis, and study skills, and work together in groups to diagnose a clinical case. □

AMA Conference cont. from pg. 9

would be addressed. In fact, Dr. James Todd, executive director of the A.M.A., stated that the credibility of Ira Magaziner, the architect of the Clinton plan, was on the line. Mr. Magaziner stated he envisions a system reform where local medical societies can serve as negotiating agents for their member physicians.

The Clinton Health Care Reform proposal along with those alternative plans will be subjected to the scrutiny of 20 committees and 40 subcommittees during the ensuing months. Both Republicans and Democrats hope to have congressional action in the house by May of 1994 and senate action hopefully will be accomplished by July of 1994.

During the meeting, conference attendees had the opportunity to meet with their own legislators to express their personal concerns and learn where their representatives stand on health system reform.

The meeting was highly productive and informative. I came away with several observations. First, our national society representatives are doing a better job of representing us than they are given credit. Second, there is a need for a greater grass roots involvement of the A.M.A. and O.S.M.A. and M.C.M.S. membership working in an organized fashion. I encourage all members of the M.C.M.S. to step to the plate and work for passage of meaningful reform which protects the rights of our patients and preserves our profession. □

Daniel W. Handel, M.D.
Chairperson
MCMS Committee on Legislation

SPECIAL REPORT – Handling Managed Care in a Successful Practice

Many Advisory readers remain relatively unaffected by managed care within their practice; many others consider it "old hat," worrying mainly if they can or should cut it off at some level. In our view, the unaffected subscribers will not stay immune. The already experienced "HMO'ers" will find themselves still more involved.

This picture–filled out by the virtual certainty of Clinton-led change in the managed care/competition direction–has caused many subscribers to ask for advice on the subject. We've combed our resources, including information from a health care law firm's client newsletter–to give you some ideas. We hope you can apply this advice to your practice, whatever your present level of managed care involvement.

Lief C. Beck

Editorial Note: We acknowledge the cooperation of Leif Beck, who has granted reprint rights for topics which have appeared in his regular monthly publication, The Physician's Advisory. His organization, The Health Care Group, with offices in Plymouth Meeting, PA, is a group of leading national consultants and attorneys specializing in medical practice organization and management.

Managed care practice is growing fast, and it is better than you may think. *Physicians typically dislike participating in HMOs and PPOs, but most of you are now into managed care. And you will almost surely be into it more heavily hereafter. It pays fairly well, and our survey reveals several surprising features.*

Seventy-eight percent of Advisory readers participate in at least one managed care plan, according to our Reader Survey #2. Not surprisingly, the level of participation varies by region in much the same way as regions vary in HMO-PPO penetration. The Southeast has the most physicians (27%) *without* such activity, while New England (11%), the Far West (18%) and the Mid-Atlantic (19%) have the fewest.

Doctors active in managed care most commonly participate in two to four plans. This varies, though, in several respects:

- Surgical specialists and hospital-based doctors (the "RAPs") more commonly participate in five to eight plans, while multi-speciality groups are evenly divided between 5-8 and 9-20 plans.
- Physicians in the Far West (California, Oregon and Washington) more commonly work in 9-20 plans.
- The number of plans increases steadily as a practice grows, and thus groups of more than thirty doctors typically participate in 9-20 plans.

A Worrisome Trend

For practices in at least one HMO/PPO, 26% of all patients they treat come from managed care plans. This is noteworthy, telling us that one out of four patients you treat is typically *not* fee-for-service! Far West and Rocky Mountain state doctors lead the way here, with 38.5% and 33% of their patients in managed care; New England doctors are not far behind at 30%.

The number of patients in your *single most active* HMO or PPO is growing rapidly. From 8.8% of total patient volume just three years ago, it grew to 12.5% in the next two years and to a current 14.4%—a 64% increase in just three years. We worry if 10% or more of your patients are in one plan, and we particularly warn against having over 20% in a single plan, so the trend is of real concern. Since this critical "load factor" varies significantly, here are bar graphs showing it by region and by practice specialty:

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Holly Ambrose
Terry Blessing
Marjorie Bosley
Vanessa Bowman
Stoney Bowser
Amy Brode
Nancy Brode
Hyland Burton Jr.
Cheryl Campolito
Cele Connelly
Tom Craven
Janine De Frank
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Tammy Sabol
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Physician's Advisory *(cont. from pg. 14)*

Percentage Of Patients Presently In Your Most Active HMO/PPO:

By Region:

New England

Mid-Atlantic

Southeast

Midwest

Southwest

Far West

Rocky Mountains

By Specialty:

Primary Care

OBG, Eye and ENT

Internal Medicine Subspecialty

Surgical Specialties

Dermatology & Allergy

Hospital-Based (rad., an., path., etc.)

Multi-Specialty

"Capitated" Patients

Only 20% of you engage in any capitation practice–paid by a fixed monthly amount rather than fee-for-service–at all. As you might expect, this fixed payment approach varies widely by specialty as follows:

Percent Of Physicians With Capitated Patients:

Primary Care

OBG, Eye & ENT

Internal Medicine Subspecialty

Surgical

Dermatology & Allergy

Hospital-Based

Multi-Specialty

Of those physicians who actually have capitation in their practice, it represents 19.1%, on average, of their total patient base.

We wonder if surgical and medical subspecialists–particularly OBGs, opthalmologists, and allergists–aren't missing the boat since so few of them participate in capitated care. It may provide a nice flow of patients along with fairly decent equivalent pay. And with reform heating up, you may not have much choice. Give it some thought.

Seventy-nine percent of doctors having capitated practice actually keep track of their services and compare the fixed payments to what they would bill under fee-for-service. Of them, 21% report receiving more than from fee-for-service, while 59% say they receive less; the remaining 20% report receiving nearly the same as if they billed more traditionally for their procedures.

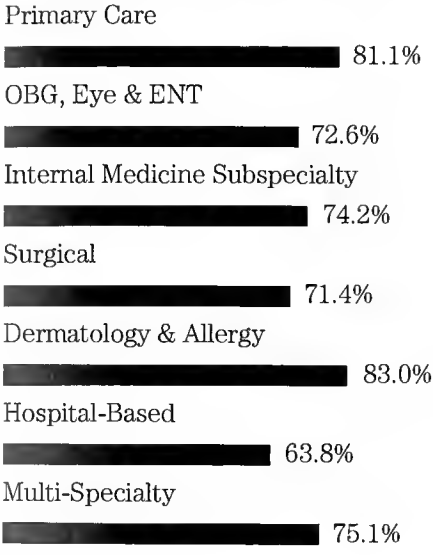
How Well Paid?

Conscious of a common complaint about managed care work, we asked how much you are paid for that activity compared to your regular fees. The overall answer–75.5% of full fees–is fairly impressive, for many doctors hardly receive that much on their Medicare and Medicaid work. Indeed, 67% of you

say you receive more from HMO/PPO work than from Medicare, while another 22% say "about the same." Only 11% of you report receiving either somewhat less or significantly less than from Medicare.

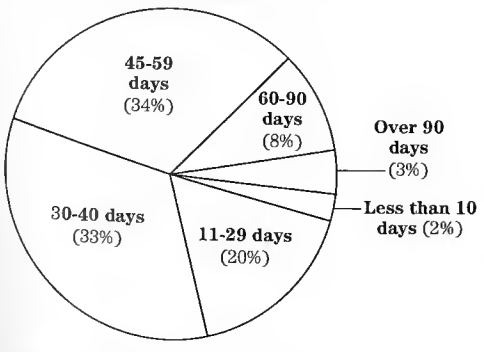
While you may fume over your Medicare Fee Schedule and similar reimbursement limits, don't thumb your nose at managed care practice. It provides a flow of patients–whether fee-for-service or capitated–for whom payment is better than you may think.

Here's how HMO/PPO payments (both capitated and fee-for-service) compare to full fees by specialty:



Payment Details

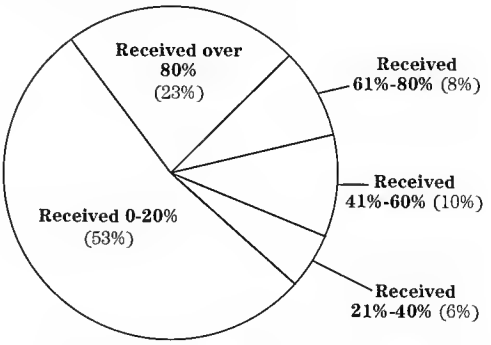
Doctors receive their HMO/PPO fee-for-service payments an average of 42.3 days after billing. Surgeons are the only significant outliers: They wait an average 50.1 days before payment. Here's how the payment delay breaks down:



That's roughly similar to the time gaps we see for non-managed care work. So while the paperwork involved in HMOs may frustrate you, you should be reasonably pleased as a matter of cash flow. Capitated programs, of course, provide a still smoother cash flow since they presumably send you a check each month on a regular schedule.

Withholds and Co-Pays

Sixty-one percent of physicians participating in managed care plans encounter "holdbacks" or "withholds"–nonpayment of a portion of their fees until a periodic utilization-type accounting occurs. For those doctors subject to withholds, their plans ultimately paid an average 38.6% of the retained amounts last year. Over half, however, reported receiving little of those funds. Here's the breakdown:



Finally, we asked about "co-pays" on your managed care work. Some 83% of participating doctors report being able to charge patient co-pays for each visit. The co-pay is most common among primary care (87%) and multi-specialty (93%) practices, while it occurs in only half of the hospital-based practices.

As we strongly advise, the majority of physicians collect co-pays at the time of service, with 83.7% doing so. Hospital-based doctors are understandably badly limited–coming in at just 15.8%. Radiologists and anesthesiologists suffer here, for it's terribly important to collect co-pays up front or else do without!

Choosing and contracting with managed care organizations.

While many of our readers participate with one or more managed care organizations, there's such growth in these "MCOs" that you will all have to make continuing choices. And this leads to contracts with the MCOs under terms that serve your practice's concerns. We're pleased to reproduce this article from a fine health care law firm–Gordon, Feinblatt, Rothman, Hoffberger & Hollander, of Baltimore, Maryland–about these matters. We consider it the best description available.

Few professional or institutional providers can service today without developing a relationship with at least one managed care company, whether it be an HMO, PPO, or some hybrid of these traditional managed care entities. Unfortunately, many providers enter these arrangements without concern for their legal and practical impact. As some providers find out too late, there's more to managed care contracting than negotiating a fee discount and signing a form agreement.

Here are ten issues to keep in mind when negotiating with a managed care organization (MCO):

A. Getting In

1. *Picking the Right Partner.* Once you've decided that a managed care relationship will improve your practice, check out your potential partners. Talk to colleagues in your field. Which companies are prompt payers! Which companies have referral networks with providers with whom you're familiar? Which companies have a record of financial soundness and a strong presence in the community? Which companies have a record of complaints with the Insurance Division?

2. *Making the Form Fit.* Once you've found an MCO to "fit" your practice, you'll likely be handed a form contract. There's no reason to accept the form on a "take it or leave it" basis; a provider of any size should be able to negotiate at least some changes. More importantly, the MCO's "take it or leave it" attitude before the relationship begins indicates a rocky road for the future.

In reviewing the contract, solicit the opinions of those whose expertise can assist you. Ask your lawyer to review the form for legal pitfalls; ask your accountant to review the payment mechanisms and to test the MCO's projections; ask your business manager to evaluate the mechanics of the contract, such as timing of reimbursement, obtaining approvals for services, use of forms, etc.

3. *Who's Responsible?* Often an MCO will establish a separate entity for the purpose of contracting with providers. If that's the case, you should ask that the parent company guarantee the obligations of this related entity. Alternatively, the MCO would purchase insolvency insurance to insure the payment of your claims or set aside a security deposit to cover payment.

B. Staying In

4. *Payment.* In many managed care arrangements, the payment provisions are quite straightforward, such as fee-for-service, discounted fee-for-service, per diem, or per case basis. The most common payment system for primary care physicians in health maintenance organizations–the "capitation" basis–is more complicated. In these arrangements, a physician is paid a fixed sum each month for each patient assigned to that physician, regardless of whether the patients receive any services.

Some portion of the capitation is typically allocated by the MCO to a "referral" pool and another portion is allocated to a "risk-sharing" or "withhold" pool. The costs of referral services for the physician's patients will be paid out of the referral pool; if referral costs exceed the amount in that pool, deductions are made from the risk-sharing pool to cover those costs. Amounts remaining in the pools at the end of the year are divided, on some negotiated basis, between the MCO and the physician.

Ideally, this system operates as an incentive to the physician to refer patients for services in a cost-effective manner because it allows the physician to share in the profits resulting form those efficient referral patterns. The physician also shares the risk that patients will require more, or more expensive, services than projected by the MCO.

Be cautious in reviewing the description of capitation based payments. Unfortunately, capitation rates are only as sound as the actuarial assumptions on which they are based. The physician is at a disadvantage because he or she cannot evaluate those assumptions. However, you can gain some perspective on the validity of the MCO's projections by asking the MCO about the level of distributions from the pools to its primary care physicians during the last five years.

The contract should also clearly place a cap on the physician's ultimate liability, either by dollar amount or through stop-loss coverage for the physician.

Finally, examine the service included in the referral pool. While it may be reasonable for the MCO to appropriately constrain *your* referral patterns, you have no ability to control the patterns of other providers; it may be unreasonable for you to bear the risk of their improper utilization of services.

5. *Covered Services.* This contract should clearly specify what services are covered. The provider should be aware, and wary, of any MCO's right to "carve-out" certain procedures during the agreement and contract with other providers to provide them. Not only will carve-outs disrupt your routine, they may also reduce the profitability of your arrangement if profitable procedures are carved out and only high cost procedures remain covered.

6. *Beware of Manuals.* Most agreements refer to "rules and regulations," "utilization review procedures," "operating manuals," or the "appeals process." Always review these procedures before signing, and try to negotiate any provisions which may be inappropriate. Once an agreement is signed, you'll be subject to all of the MCO's rules, all of which may be changed at the MCO's convenience, unless your agreement says something to the contrary.

7. *Right to Refuse Additional Patients.* Providers need to control practice growth, and the practice's pay or mix. While an MCO will usually permit a provider to refuse to accept any new MCO patients, that is, "close" the practice, some form MCO agreements also require that a closed practice remain closed to all patients of any MCO. Obviously, a provider should avoid this restriction.

8. *Indemnification.* The most onerous agreements will state that the provider must indemnify the MCO, that is, pay the MCO for any costs it incurs as a result of the provider's conduct. A provider accepts an unreasonable risk when it agrees to indemnify an MCO. Virtually all of the risk inherent in the contractual relationship is then shifted to the provider, and a provider's malpractice insurance, or other business insurance, won't cover this liability.

C. Getting Out

9. *Termination.* In the beginning of a relationship most people don't consider the possibility that things just won't work out. A contract that offers both parties a right to terminate the agreement without cause offers the greatest flexibility and protects you from the risk of an unprofitable arrangement. On the other hand, if MCO patients comprise a large percentage of your patient base, letting the MCO terminate quickly may cause turmoil. Termination provisions must be considered carefully and consistently with the long term goals of your practice.

10. *Continuation of Treatment.* Patient needs are primary when a provider terminates its relationship with an MCO. Generally, a contract requires the provider to continue to treat the MCO's patients during a transition period. While it's certainly reasonable to continue to treat patients who are currently hospitalized until their discharge, it's not reasonable to require a physician to treat the MCO patients for a period over 90 days.

Providers should not be taking their relationships with MCO's for granted. On the contrary, providers should be "managing" these relationships carefully.

Seven ways to hold down costs on your managed care work.

Capitated patients are becoming a large part of practice whether you like it or not. Rather than grumble about this work, recognize how it may force you to become more cost-effective–and hence more profitable–than you expect.

Though there's great variation from place to place, managed care has become a significant factor in most of our readers' practices. As previously mentioned, 26% of our readers' patients came from managed care in 1992. Some 20% of doctors are involved in capitated practice, it in turn constituting 19.1% of their patient base. For some doctors in some areas, these patients comprise up to 40%, 50% and even more of their total.

Given the health care reform picture, it seems almost certain that your capitated practice picture will grow.

Most of the capitation is still with primary care, but an increasing number of specialists are now accepting HMO patients on a capitated basis. Specialists should, by the way, be willing to accept a capitated patient population so long as they critically evaluate and monitor the assumptions used in fixing the monthly payment. They also must assure that they have some protection against patient-dumping–being stuck with a group of patients inordinately needing their specialty's attention.

Multi-specialty groups, of course, have an advantage in taking on large patient bases. They can assume responsibility and control over primary care and specialist services in one capitated fee.

An Important Mindset

Robert J. Erra, senior vice-president and chief operating officer of Scripps Clinic & Research Foundation, in LaJolla, CA, spoke on this subject at a recent Medical Group Management Association Annual Conference. His talk, "Maximizing Income by Increasing Revenues and Controlling Costs," discussed approaches taken by his huge physician group which can be equally useful to smaller practices. At minimum, they articulate a philosophy which all doctors should adopt for their capitated patient work.

On the cost side, Mr. Erra said you will "enhance medical group income by reducing the *unit cost* of providing service" (emphasis ours). His compelling point is that the physician is a major element of the unit cost–even if he or she is a "partner."

Privately practicing doctors find this concept hard to understand. You probably say, "I produce the revenues, so the bottom line is mine," ignoring that you are a significant cost factor as well as the owner.

Specific Tips

Thus strategies that make you–the physician–more cost-effective will make you more profitable.

In this expanded view of cost control, Mr. Erra recommended seven specific approaches. They are critical if you have many capitated patients, but they are just as sensible for your entire practice.

1. Don't divide income on production, at least not as to your fixed pay work. Taking pay on the basis of *how much* you do–particularly on how many charges you put on the books–flies in the face of capitated practice's basic philosophy.

2. Collect the patient co-pays aggressively. Even if only a couple of dollars per visit, requiring payment educates the patient to avoid over-using your services. And besides, those dollars *are* revenue and every bit counts.

3. Modify capitated patients' expectations of what service they will receive. Managed care advertising makes it seem that doctors are available for every sniffle and bump, so it's up to you to train these patients as to when they should or should not see you. Your staff's telephone techniques become important here, as employees learn to triage incoming calls to keep you from being overwhelmed.

4. Establish physician productivity standards. Picking up on the concept of "patient-per-hour rate," Mr. Erra said his group used time sheets to help doctors evaluate their activities. An increase of just 10% in physician time efficiency yields tremendous increases in earnings.

5. Hold down your nurse staffing to the lowest common denominator. RNs and LPNs are costly, and they are scarce enough that they will almost surely become still more expensive. So critically evaluate whether you *really* need an RN/LPN, or whether you are

cont. on pg. 22

Physician's Advisory *(cont. from pg. 20)*

clinging to old habits and preferences.

6. Use cost-effective hospitals. Your withhold and succeeding years' capitated fees may depend on the cost of your assigned patients' *total care.* If one of your hospitals is more cost-effective than the other(s), particularly as to specialists' needs, consider admitting your HMO patients there.

7. Watch the prescription drug options. As with hospital selections, one drug may be less expensive than another and yet be equally effective. Think about the costs when you prescribe.

Mr. Erra concludes that capitated practice "clearly produces some benefits to a practice by forcing it to look at costs." Beyond routine attention to overtime, purchases and office maintenance, start looking at cost in its larger scope: physician time and patient usage.

What's your "patient-per-hour rate?"
"Information is power," so use this valuable statistic to measure your physician productivity. Calculate this once-a-year "snapshot" of how you practice, from which a variety of management decisions may flow.

The above article's fourth point urged keeping track of physician-level productivity by plotting his or her "patient-per-hour rate." Medical building architects, Richard C. Haines, Jr., and Michael Holmes, of Medical Design International (MDI), focus on this efficiency factor when they evaluate a practice's space needs. Mr. Holmes gave a speech on this point which we think helps flesh-out the concept.

As Mr. Holmes put it, physician productivity is a practice's heartbeat because your work pace dictates your economics. What is more, an entire range of management decisions–staffing, space design and patient scheduling–are determined by the doctors' patterns.

An Annual Snapshot

That's why it is important to measure the physician's production level. Mr. Holmes says MDI uses a basic unit measure–"patients per hour"–as the tool for doing so. It's his starting point in deciding on office space needs, but he suggests a periodic review after that.

To determine your patient-per-hour rate, randomly select ten recent half-day office sessions. Total up the number of patients seen during those sessions and divide it by the "elapsed time." This time factor is basically the number of office hours in those sessions, but adjust it for late arrival and late stay to obtain the *actually* elapsed time spent seeing the patients.

Repeat the calculation once a year so you can compare these "snapshots" of your productivity level. If you have different types of office sessions–perhaps solely for check-ups or post-op visits–run snapshots on these sessions as well as your regular ones. They may help you identify patterns and trends in the way you work.

In group practices, run the annual calculations separately for each member (and for each department in multispecialty groups). The per-doctor variations furnish valuable data for individualizing doctors' appointment books, exam room assignments and assistant needs. And if the data show that a member is considerably slower than his partners, maybe it will help him reassess his style.

Information Is Power

It's simple to set up this process as an annual routine. While some physicians may prefer not to know things that put their practice style in question, you are better off in the long run with actual data than with mere perceptions–particularly when the data will make your practice more cost-efficient and productive.

Fitting capitated patients into your business system.
You'll have to modify your billing and collection systems if you have HMO patients on a capitation basis. Here are suggestions how to do it.

As the trend towards capitated medicine–treating patients on a flat monthly charge rather than fee-for-service–continues, you may have to accommodate the arrangements within your regular business system. Otherwise, the routines you use for our fee-for-service patients will control

in this very different kind of practice concept. That won't serve your practice well.

Start by assigning each HMO capitation patient a specially colored chart folder so that physician and assistant can easily identify the patient's out-of-the-ordinary arrangement. All doctors and staff will more likely notice, too, when "no charge" entries for covered services and charges for any special patient-pay fees (like co-pays, surcharges and charges for non-covered services) apply.

Posting Charges and Billing Them

Your computer system presumably allows your receptionist or cashier to identify each capitated patient and to suppress regular billing for his or her visits. Still, your system should record those transactions–although separately from your fee-for-service work.

If you are on a manual billing system, perhaps a peg-board, be sure to have separate columns for the capitated patients' "charges." When these patients check out, attempt to collect on-the-spot any special charges they owe and record their payments in one capitation column.

Be sure, too, that your system allows you to record the normal fee-for-service charges for each service even if it is covered by the monthly HMO payments. This information allows you to compare what you would have earned at full fees against your HMO receipts.

You do not, of course, directly bill the monthly capitation fees, but handle any surcharges and "patient-pay" items as you would any other receivable. All such special charges should be collected or arranged for special payment at the time of the patient's visit. It's essential to focus on immediate payment when obstensible "free" services are being provided, although a few of them will presumably fall through the cracks and require normal fee-for-service billing. □

Did You Know?...

Medicaid providers cannot make monetary contributions to the campaign of those candidates running for the office of State Attorney General.

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Direct your attention, and that of your office manager, to a program designed to help you be paid for services you have honorably performed, and one allowing you to show a doctor's traditional compassion for a distressed patient.

Consumer Credit Counseling Service (CCCS) is a non-profit organization, a part of the Family Service Agency, affiliated with the National Foundation for Consumer Credit. It is a United Way Agency, and is certified by a national accrediting board.

Those troubled by debt may be referred to or seek help from CCCS in managing their income and spending so as to adopt a reasonable was of living and pay their creditors what they owe; the final goal would be living largely on a cash basis, and avoiding uncontrolled debt.

Such a program seeks to avoid bankruptcy, so damaging to both creditor and debtor.

Briefly, clients are counseled on their obligation to pay debts and on a lifestyle befitting their income. They agree to a budget with which they can live, and one which frequently eliminates unnecessary expenses (e.g., premium channels on T.V., big boat). The budget must include a regular sum which clients deposit with CCCS monthly. From this money, the agency pays the creditors until the debts are discharged.

The debtor pays by accepting the needed discipline. The creditor pays by agreeing to the total discharge of the debt regularly, but over a longer period.

A letter is sent to the creditor by CCCS, confirming the debt of the client, his or her income, and the proposed monthly payments. Payments may increase as other smaller debts are discharged. If the creditor feels the arrangements are not suitable, he or she may call the counselor whose name appears on the letter. Creditors who elect to participate in specific cases, return the letters with their signatures. They remain free, however unwise they might be to do so, to pursue payment of the debt by any other means open to them by law, short of garnishment of wages. Good taste would suggest that such actions and collection calls be suspended while the patients are in the program, trying their best to pay their debts.

Should the debtor fail to deposit the agreed amount for two months, the creditor is notified by the agency that the debtor has been dropped from the program, and that the creditor is freed from the agreement.

The debts are assigned priority by the agency in only one way. Secured debts (e.g., car, house) are paid first, and then all unsecured debts (e.g., credit card, charge accounts, doctor, hospital) are paid equitably. In short, medical bills are NOT relegated to the bottom of the list.

There is no charge made to the debtor, by terms of the charter of the CCCS and by Ohio law. The service is supported by United Way and by contributions. Creditors are urged to contribute up to 15 percent of the debt collected by the service, but they are not obligated to do so; it seems honorable to support the agency which has helped collect a debt that otherwise might not be paid. □

Robert B. McConnell, M.D.
CCCS Advisory Board

Country Home

Original Pen & Ink

Harriet Cowen

Wouldn't you just love to live here? Many of us still have a love affair with the idea of a country estate flavored by New England quaintness. I'm not sure anyone could give this image more justice than this month's featured artist. Harriet Cowen was born in Fairfield, Maine, in 1925 on a 200-acre farm dotted with apple orchards, cattle, corn and bean fields. As a young child, Harriet began sketching with pencil the scenes around her. Her mother was always encouraging her to read instead, but nothing could keep Harriet away from her drawing. She recalls a day she even stayed home from school just to draw a picture of a baby, and Harriet remembers she never erased once.

There were no art classes in school, and summers were spent working on the farm, so Harriet was unable to study art anywhere. Throughout grade school, Harriet was the class artist. It was her job to draw pictures on the blackboard for decorations each week. And because her family was poor, Harriet's father set up a blackboard in the dining room where Harriet drew pictures ... a simple but clever way to get framed art hung in the home! As a youngster, Harriet sent her drawings to childrens' magazines. When she was 12 and 13, she was most thrilled about her work being accepted by *Wee Wisdom,* the children's magazine. High school had no art classes, but Harriet found an outlet doing all the art work for the year book.

Like most artists, Harriet is gifted in more than one area. In junior high, she began to study the violin. This led to scholarships, bringing Harriet a Bachelor of Music degree from New England Conservatory in Boston. During her summer vacations, she earned money playing dinner music in hotels and even playing the drums for a band on Saturday nights. After college, Harriet became head of grade school music at a school in Wichita, Kansas, where she also became a member of the Wichita Symphony Orchestra. Harriet taught for 4 years, married and started raising a family. Seeing her deep desire to draw again, her husband enrolled her in an art instruction school that taught through correspondence. Here Harriet learned her pen and ink techniques, leaving her pencil drawings behind. The family then moved to Canton, Ohio. When her husband died, she turned completely to art as a means to support her family.

Harriet uses a kohinoor pen with small stylet sizes of triple 000 or 5 and 6 zero. The pen is very fine tipped. She became accustomed to using this pen when she worked for 7 years for a cartographer in Canton, drawing the fine details on maps. Every imaginable subject has flowed from her pen with exquisite and masterly perfection. She has a passion for history and it shows in her landscapes, still lifes, architecture, and portraits. She captures them all and brings unbelievable beauty, sometimes reminiscent of the old etching masters.

In recent years, Harriet has begun to use watercolor washes with her pen and inks for added beauty and interest.

Harriet is probably best known throughout the United States for her house portraits and family portraits. She receives commissions from all over the country and continues to make new friends at art shows.

Harriet recently moved to Virginia where after 38 years away from music, she joined the orchestra, a quartet and a trio. She is trying to combine music with her art, but too many conflicts have emerged. Harriet no longer sells her original pen and inks but now makes prints and hand colors them. She also sells over 40 different note cards of commissioned stationary. The demands on her to teach are great, but Harriet has no time for it. She has been commissioned to illustrate an ABC book and to do a series of books on pen and ink drawing. Harriet has won recognition with her artistic talents at national and regional art contests and exhibits. Her originals hang in hundreds of prestigious homes throughout the United States. On December 3-5 and 10-12, Harriet will be at the E.J. Thomas Hall in Akron, Ohio, for a Christmas Arts and Crafts Show. □

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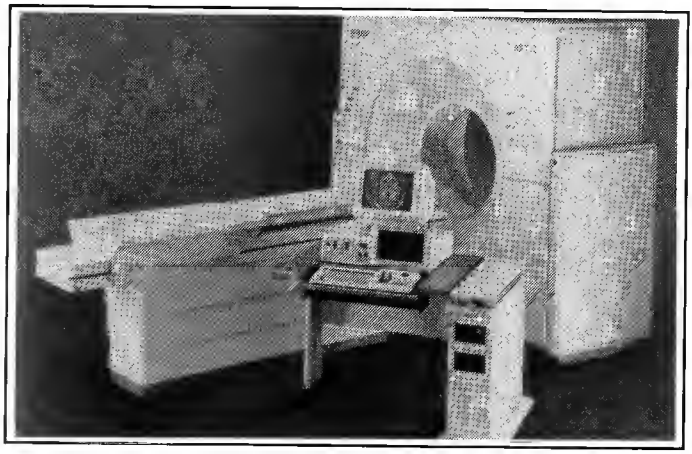

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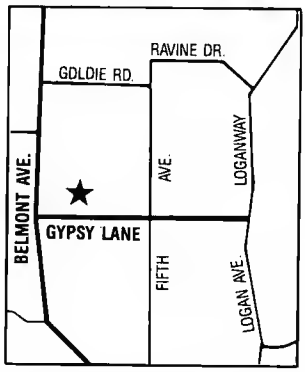

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60 Years Ago — Sept./Oct. 1933

There was a sudden increase in the number of cases of infantile paralysis, now known by the more scientific name of poliomyelitis. Eighteen cases were reported in July. Convalescent serum was the recommended treatment. President Roosevelt had passed the National Recovery Act (NRA) which required a 40-hour week and a minimum wage of $14 a week.

50 Years Ago — Sept./Oct. 1943

World War II was in full swing and the *Bulletin* was full of letters from members in military service in far away places. The *Bulletin* was in great demand then. There were four full pages of names and addresses for local physicians who were in the service. Those physicians who remained at home were feeling the load. Acting President **Elmer Nagle** urged all members to protest against the Wagner Murray Dingle bill which proposed a form of socialized medicine under social security.

40 Years Ago — Sept./Oct. 1953

The war was over and business was booming. Seven cases of polio were reported that month and also a sharp increase in cases of infectious hepatitis. **Kenneth Hovanic** and **Raymond Boniface** had an interesting article on Tay-Sach's Disease, reporting on a case seen at St. Elizabeth Hospital where Dr. Boniface was an intern. President **Verne Goodwin** and Editor **Harold Reese** urged the members to start the new season with a big attendance by offering them free dinners.

30 Years Ago — Sept./Oct. 1963

Robert R. Fisher, MD

A leading article on myocardial revascularization by **Elias Saadi, Edward Massulo** and **Anthony Riberi** described their method of treatment of intractable angina by transplanting the internal mammary artery and presented a case report. **Richard Roland** and **John LaManna, Sr.,** organized a picnic reception for the new YHA interns at the home of **Dr. LaManna.** **John Melnick** became a full-time member of the radiology department of the South Side Hospital.

20 Years Ago — Sept./Oct. 1973

The speaker for the September meeting was Stanley S. Peterson, M.D., president of the newly formed American Federation of Physicians and Dentists (AFPD) an unaffiliated national union. There was no comment on how well it was received. **J. Paul Harvey** helped get the student clinic at YSU off to a good start by donating all of his office equipment. **Bertie B. Burrowes** was appointed head of the medical division of the Buckeye Elks fund drive for their Youth Development Center on North Ave. **Robert Hritzo** held another great dog show at the Canfield Fairgrounds, sponsored by the Mahoning Shenango Kennel Club, of which he was president.

10 Years Ago — Sept./Oct. 1983

With the dawn of the age of the computer, President **Paul Mahar, Jr.,** was concerned that today's young physicians might be so enamored with the hardware of medicine that they might lose track of the ART of medicine. **Frank Gelbman** pointed out that health care costs at that time consumed 10.5 percent of the gross national product. He blamed mostly inflation and bureaucracy. Twelve new members were listed. These were **Malcolm Arnold, B. Dayal, Thomas Fogarty, Donald Fox, Norton German, Kim Goldenberg, Prasad Guttikonda, Bee Min Lin, J. Paul Moore, N.N. Patel, Robert Spratt** and **Donald Tamulolonis.** □

PHYSICIAN DIRECTORIES AVAILABLE

Copies of The Mahoning County Medical Society's first Physician Directory are still available for sale at the Society office. This handy reference guide to our membership may be purchased for $20. Anyone wishing to purchase additional copies may contact the Society office at 788-4700.

Society Meeting

Dr. Walter A. Reiling, president of the OSMA, presented an update on the OSMA Task Force on Health Care Reform when members and guests met at the Youngstown Club on Tuesday, September 21, 1993. Dr. Reiling, who was accompanied by D. Brent Mulgrew, executive director of the OSMA, noted that all members would receive copies of the recommendations of the task force. The OSMA will sponsor regional conferences to give members the opportunity to hear the recommendations first-hand.

Dr. Eric Svenson, president, presided over the business meeting. Dr. Norton German, chairperson of the foundation committee, announced that two loans totaling $5,000 were granted to two students through the Foundation Loan Program. The nominating committee, which includes Drs. Chester Amedia, Jane Butterworth, David Dunch, James Might, Armand Minotti and Eric Svenson, will report its nominations to Council at the November meeting.

New members in attendance included Dr. Howard G. Slemmons and residents Drs. Mohammad Jamshidi, Ruben Ortiz and Pedro Yepes.

The Upjohn Company, represented by David Call and Gregg Clark, provided the product Display.

The next Society meeting will be held on November 16, 1993 at the Youngstown Club.

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